Date: [Date]

To: [Name of Custodian of Records or Doctor]
Facility Name: [Clinic or Hospital Name]
Address: [Street Address, City, State, Zip Code]

RE: AUTHORIZATION FOR RELEASE OF COMPLETE MEDICAL RECORDS

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Social Security Number (Optional): [SSN]
Patient Phone: [Phone Number]

To Whom It May Concern,

I am writing to formally instruct you to release a complete copy of my entire medical history and all related records maintained by your facility. This request includes, but is not limited to:

- All physician notes and clinical summaries
- Diagnostic test results (lab reports, X-rays, MRIs, CT scans)
- Immunization records
- Prescription history
- Surgical reports and discharge summaries
- Billing and insurance records

Please deliver these records to the following recipient:

Name/Entity: [Name of Person or Office receiving records]
Address: [Recipient Mailing Address]
Email/Fax (if applicable): [Recipient Contact Info]

This authorization is valid for 90 days from the date of signature unless revoked by me in writing. I understand that there may be a reasonable fee for the copying and postage of these records. Please notify me in advance of the total cost.

Thank you for your prompt attention to this matter.

Sincerely,

_____
[Patient or Legal Representative Signature]

[Printed Name]